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C 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare recertification survey conducted in your facility on 3/2/09 through 3/5/09. There were four inpatients at the time of the survey. Twenty-three records were reviewed. The following Condition of Participation was not met: CFR 485.635 Provision of Services Standard level deficiencies were identified. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	C 000		
C 270	485.635 PROVISION OF SERVICES Provision of Services This CONDITION is not met as evidenced by: Based on observation, interviews and facility documentation, it was determined the facility did not meet the Condition of Participation for Provision of Services. The facility failed to: 1) To implement or follow policies to ensure the nutritional needs of inpatients were met in accordance with recognized dietary practices (See Tag 0279).	C 270		
C 276	485.635(a)(3)(iv) PATIENT CARE POLICIES [The policies include the following:]	C 276		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 276	Continued From page 1 (iv) rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use. This STANDARD is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to ensure outdated medications were removed from storage. Findings include: On 3/2/09, the crash cart in the surgery room was inspected. The following expired medications were found: Dextrose 25 Grams/50 milliliter (ml), 2 syringes, expiration 1/09. Lidocaine 2 %/100 milligrams (mg), 2 syringes, expiration 2/09 Epinephrine 1:10,000, 2 syringes, expiration 11/08 Flumazenil, 0.5 mg/ml, 2 vials, expiration 11/08 Metoclopramide 10 mg/2 ml, 2 vials, expiration 10/08 On 3/3/09, the pharmacy stock was inspected. The following expired medications were found: Neomycin ophthalmic ointment, expiration 12/08 Bacitracin ophthalmic ointment, expiration 1/09 Penicillin VK, 1 bottle for reconstitution, expiration 1/09 Glypizide 2.5 mg, 1 bottle, expiration 1/09 Captopril 12.5 mg, 1 bottle, expiration 1/09	C 276		

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C 276	Continued From page 2 Lisinopril 40 mg, expiration 11/08 Theravite liquid, 1 bottle, expiration 12/08 Senna liquid, 1 bottle, expiration 2/09 Enalapril, 1 bottle, expiration 2/09 Promethazine HCL suppositories, 23 suppositories, expiration 2/09 Prednisone 5 mg, 1 bottle, expiration 2/09 On 3/3/09, the facility's Director of Nurses was interviewed. She explained that the medications were checked monthly for expirations and the expired medications were separated from the stock medications. She stated the expired medications that were found must have been missed. The facility's policy and procedure for monitoring expiration dates was reviewed and revealed "Expiration dates of drugs and devises shall be checked during the monthly medication area inspection and all drugs and devices scheduled to expired during the next month shall be removed, upon receipt of the medication the outdated will be removed from stock." The facility's policy and procedure for stocked drugs in the surgery room was reviewed and revealed the certified registered nurse anesthetist was to "Check the Crash Cart before and after each surgical day to ensure emergency drugs are always readily available. Notify the OR Supervisor to replace any used or outdated drugs."	C 276		
C 279	485.635(a)(3)(vii) PATIENT CARE POLICIES [The policies include the following:] (vii) If the CAH furnishes inpatient services, procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the	C 279		

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practitioner responsible for the care of the patients, and that the requirement of §485.25(i) is met with respect to inpatients receiving posthospital SNF care.

This STANDARD is not met as evidenced by:
Based on observation, interview and policy review, the facility did not ensure that the nutritional needs of inpatients were met in accordance with recognized dietary practices.

Findings include:

An inspection of the facility's kitchen on 3/2/09 procured the following findings:

Food dating: In the two-door refrigerator there were opened containers of cottage cheese and sour cream which had not been dated. In the three-door refrigerator a turkey/egg salad was undated. In the dry storage room a pan of baked bread was undated. The dietary manager stated that these items were supposed to have been dated. The facility's policy included the following statements: "All leftovers...are marked with the name of the item and dated when prepared. Hazardous foods will be stored for a maximum of 72 hours from the preparation time."

Food storage: In the walk-in refrigerator it was observed that ham, deli meats, and hot dogs were being stored on the same shelf as raw beef and raw chicken. There was no written policy pertaining to the appropriate storage of refrigerated foods.

Food temperatures: An infrared thermometer was observed in the kitchen. The cook stated

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that a stem thermometer was available, but that the infrared thermometer had been the primary thermometer used in the kitchen for the past five years. He further reported that the use of the infrared thermometer was not always reliable in that when some items such as soups were stirred, there could be different temperature readings. A review of the food temperature log for the month of February revealed that temperatures had been taken for seven days. Food temperatures had not been periodically checked when delivered to patients per facility policy. The dietary manager could not explain why food temperatures had not been regularly taken. The kitchen's written policy read, "The cook is responsible for recording the temperature of all hot and cold foods on the regular menu before tray line starts. Temperatures are to be logged on the cycle menu. The Nutritional Services supervisor or designee will monitor food temperatures at the patient unit a minimum of six meals per week."

Sanitizing solutions: The kitchen did not have a Quat pH testing kit available. According to the cook the sanitizing solutions of the wiping cloth buckets, spray bottles, and dish sink were not being tested regularly. The written policy revealed the following: "The cook will maintain the log of sanitizing solution once per shift."

Kitchen equipment: The dishwasher machine using hot water for sanitizing was not consistently reaching a temperature of 180 degrees Fahrenheit (F) or above for each rinse cycle. One of the facility's infection control policies specified that the dishwasher was to maintain a final sanitation rinse of 180 degrees F. The can opener blade was soiled.

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C 279	Continued From page 5 Toxic chemicals: A germicidal aerosol cleaner was observed being used on walls at 10:00 AM during food preparation. A precautionary statement on the product included the following: "Avoid breathing spray mist. Wear safety glasses or goggles. Do not use on dishware, utensils, or cookware." The cook reported that she had obtained the cleaner from housekeeping and had been using it "for a while." The kitchen's written policy revealed "Toxic cleaning materials shall be used in such a manner as not to contaminate food." Diet instruction: Patient #23 was admitted on 2/24/09 with diagnoses that included insulin-dependent diabetes and hypertension. Record review revealed that the patient had been prescribed a diabetic diet and that her fasting glucose levels during her hospital stay ranged from 160 to 220. The patient had not received any diet instruction before being discharged on 2/26/09. The facility's nutrition policy manual included the following policies: 1) "Prior to discharge the dietitian or designee will assess patient knowledge of his/her medical condition, knowledge of the therapeutic diet that the provider has ordered, and will provide instruction to remedy any knowledge deficit" and 2) "All patients on modified diets receive counseling and are provided with written instructional materials by the dietitian as appropriate." Interviews with both the Director of Nursing (DON) and the dietitian on 3/4/09 confirmed that patients on therapeutic diets were not routinely assessed of their knowledge of prescribed diets nor given any diet instruction. The DON admitted that the facility had not been incorporating the policies of the nutrition manual into everyday practice.	C 279		

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Communication between Nutrition Services and Nursing: In the record for discharged Patient #23 the Food Preference Interview form was missing. Upon interviewing dietary staff it was discovered that the form had been completed but that the original copy had been kept in the kitchen. The dietary aid stated that the procedure was to make a copy of the form and give the original to Nursing. She did not know why this procedure, as written in the policy manual, was not consistently being followed.
Patient #22 was admitted to the facility on 3/2/09, with the primary diagnoses of acute pyelonephritis, acute bronchitis and dehydration. Patient #22 was ordered to have intravenous fluids at 125 cubic centimeters (cc) an hour. The initial nursing evaluation history completed on 3/2/09 revealed Patient #22 had a language barrier. The evaluation indicated there were no allergies. The physician ordered a low sodium cardiac diet.

A food preference interview was conducted by a dietary staff on 3/2/09. This interview revealed Patient #22 was lactose intolerant and a vegetarian (no meat or eggs). The dietary staff also indicated the family would be providing food. The interview form was located in the clinical record but the charge nurse confirmed these forms were not forwarded to the dietician with the Nutritional Screening evaluation.

A Nutritional Risk Screening was completed by the nurse on 3/2/09, and e-mailed to the dietician. This evaluation did not include Patient #22 was receiving intravenous fluids, was vegetarian and lactose intolerant, or that the family was going to be providing foods.

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C 279	Continued From page 7 An interview with the dietician on 3/4/09, was conducted by telephone at 10:45 AM. The dietician confirmed she was just responding to the e-mail sent on 3/2/09. The dietician was asked if her recommendations would reflect that the patient was vegetarian, lactose intolerant, that the family was providing all the food or that Patient #22 was on intravenous fluids. The dietician confirmed she was not aware of these specifics of Patient #22's dietary needs. Review of Patient #22's care plans on 3/3/09, revealed no care plan was initiated to incorporate the dietary conditions of the family supplying the food and educating them on what a low sodium cardiac diet was.	C 279		
C 280	485.635(a)(4) PATIENT CARE POLICIES These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH. This STANDARD is not met as evidenced by: Based on policy review and interview, the facility failed to provide evidence that a professional group reviewed and revised policy and procedure manuals on an annual basis. Findings include: A review of the medical records policy and procedure manual revealed that the last review by the professional group was dated 2003. The facility had converted the hard copy medical record to an electronic medical record beginning in 2006. The electronic medical record was not addressed anywhere in the policy and procedure	C 280		

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C 280	Continued From page 8 manual. A conversation with the medical records administrator acknowledged the manual needed updating and review. On 3/4/09, the Nursing policies and procedures manuals were reviewed. The signature sheet indicated the Nursing policies and procedures manuals were last reviewed on 12/7/07. On 3/2/09, the facility's policy and procedures for the Operating Room were reviewed. The signature sheet indicated the Operating Room Policy and Procedure manual was last reviewed on 12/10/07. On 3/3/09, the facility's policy and procedures for the Pharmacy were reviewed. The signature sheet indicated the Pharmacy Policy and Procedure manual was last reviewed on 12/10/07.	C 280		
C 294	485.635(d) NURSING SERVICES Nursing services must meet the needs of patients. This STANDARD is not met as evidenced by: Based on record review, policy review and interview, the facility failed to ensure that nursing services provided met the needs of 2 of 5 current patients. (#2, #22) Findings include: Patient #2 was admitted to the facility on 3/2/09 with the primary diagnoses of hypocoagulation state, epigastric and chest pain. A review of the clinical record revealed the physician suspected Patient #2 was inappropriately taking her anticoagulation medication, Coumadin, which resulted in a decreased ability to clot. He ordered the nursing staff to observe Patient #2 for visible	C 294		

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or non-visible signs and symptoms of bleeding, such as bruising or blood in the stool or urine.

The clinical record revealed that at 10:30 PM on 3/2/09, Patient #2 was found on the floor sitting next to the bed. No injuries were identified. An entry at 2:00 AM on 3/3/09 (approximately three and a half hours later), the nurse indicated that neurological checks were being done and that Patient #2 was developing bruising around her left eye, left hip and right shoulder. This entry did not indicate that the physician was notified. The clinical record revealed that the neurological checks were done at 10:30 PM on 3/2/09. The second entry was timed 2:00 AM but not dated. The third neurological check was done on 3/4/09 at 8:00 AM.

An interview with the registered nurse, Employee #1 at 8:30 AM on 3/4/09, revealed she thought Patient #2 had fallen the previous night and that the neuro entries were from 3/3/09. This nurse also stated that the neuro checks were to be done every four hours, that there was no progressive assessments, for example: such as twice every 15 minutes then twice every 30 minutes, then every hour for two hours or any other variation if the neuro checks were stable or unstable. The nurse acknowledged that the entries of the neuro check sheet did not indicate neuro checks were done every four hours.

Review of the neurological check policy effective 4/1/00, indicated neuro checks were to be done on cerebral vascular accidents, suspected head injuries and hypertensive patients with high blood pressure. The policy does not describe how frequent these neuro checks were to be performed.

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C 294	Continued From page 10 An interview with the Director of Nursing at 1:30 PM on 3/4/09, confirmed that as far as the Director of Nursing was aware, this was the current policy. She stated "the physician was to be called and he/she would give the specific parameters of how often neuro checks were to be done". The Director of Nursing confirmed this was not included in the current policy. The Director of Nursing also confirmed that nursing could make judgements of how frequently neuro checks were to be done if there was obvious injury. The DON acknowledged that with the increased risk of bleeding that Patient #2 had, intracranial bleeding could have occurred and not be obvious without frequent neuro checks. An interview with the registered nurse, Employee #1 on 3/4/09, revealed that the family of Patient #2 were going to be approached regarding better medication management regarding Patient #2's Coumadin therapy when they came in today to take Patient #2 home. Patient #2 had been admitted on 3/1/09, and her discharge was planned for noon today. The charge nurse confirmed the family had not been involved in any discharge planning regarding Patient #2's need prior to today.	C 294		
C 297	485.635(d)(3) NURSING SERVICES All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.	C 297		

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C 297	Continued From page 11 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure patients received medications as ordered by the physician in 2 of 5 current patients. (#3, #1) Findings Include: Patient #3 was admitted to the facility on 2/25/09 with a primary diagnosis of bacterial sepsis. Physician orders indicated that Patient #3 was ordered two antibiotics; Vancomycin intravenous daily and Primaxin intravenous every twelve hours. Review of the medication administration record revealed that the Primaxin was given only once a day from 2/24/09-3/1/09. There was no documentation as to why the night dose was not given. There was no documentation at all for 2/24/09 and 2/25/09. On 2/26/09-3/1/09, the 3:00 AM dose was circled. An interview with the registered nurse, Employee #2, on 3/3/09 confirmed a "circled dose" indicated the dose was not given. There was no documentation the physician was informed. Patient #1 was admitted to the facility 2/27/09, with diagnoses of fecal impaction and small bowel obstruction. He was discharged on 3./3/09. His past medical history included coronary artery disease and hypertension. Review of the physician orders included his current medication regime. One of these medications was isosorbide dinitrate 10 milligrams twice a day. Isosorbide dinitrate was a medication used to dilate coronary arteries.	C 297		

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C 297	Continued From page 12 Review of the clinical record revealed Patient #1 did not receive this medication at all during his hospital stay. The medication administration record revealed each dose was circled. An interview with the registered nurse, Employee #2 on 3/4/09 confirmed a "circled dose" indicated the dose was not given. There was no documentation the physician was informed. An interview with the registered nurse, Employee #2 revealed that isosorbide dinitrate was not one of the medications available from the hospital pharmacy. In these circumstances, the families were asked to bring the medications from homes. She confirmed there was no evidence the family had been asked about this medication, nor was there any evidence the physician had been notified. An interview with the Director of Nursing on 3/4/09, revealed the hospital had the ability to order non-stocked medication from a local supermarket pharmacy. The Director of Nursing could not explain why this was not done for Patient #1. She also confirmed she had not received any documentation from the staff to inform her medications were not available for these two patients.	C 297		
C 298	485.635(d)(4) NURSING SERVICES A nursing care plan must be developed and kept current for each inpatient. This STANDARD is not met as evidenced by: Based on facility policy, record review and interview, the facility failed to ensure that nursing care plans were developed, individualized and kept current for each inpatient in five of five current inpatients. (#22, #2, #4, #3, #1)	C 298		

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Findings Include:

Review of the facility policy for care planning effective 4/1/00 indicated that care plans were to be individualized and interdisciplinary. The policy described that within eight hours of admission all patients were to have a Plan of Care, that was individualized. This Plan of Care was based on patient diagnosis and assessment. The Plan of Care was to address learning needs of the patient and/or family, be updated as necessary and involve all disciplines.

Patient #22 was admitted to the facility on 3/2/09. Her primary diagnoses included dehydration, acute pyelonephritis and acute bronchitis. The physician ordered a low sodium cardiac diet. Part of her nursing assessment and dietary preferences identified she was a vegetarian and lactose intolerant. She also required an ethnic diet, which her family would provide.

Review of the care plans on 3/4/09, two days after admission revealed there were no care plans for Patient #22's dietary needs and requirements. Review of the care plans that were initiated included one for dehydration. This care plan indicated that oral fluids should be encouraged up to 2000 cubic centimeters (cc) a shift, approximately eight cups.

Review of the intake and output sheets for the first three days of Patient #22's hospital stay revealed Patient #22 consumed only 640 cc on 3/2/09, 1380 cc on 3/3/09, and 800 cc on 3/4/09. The intake and output records also revealed that on 3/4/09, Patient #22 only had 200 cc of fluid for the 7 AM-3 PM shift. There was no entry of what

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	291300	A. BUILDING _____ B. WING _____	03/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT GRANT GENERAL HOSPITAL	FIRST AND A STREETS HAWTHORNE, NV 89415

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C 298	Continued From page 14 Patient #22's food consumption was. An interview on 3/3/09, with a registered nurse, Employee #2, confirmed this was an eight hour shift. She also confirmed that the certified nursing assistants (CNA) were to read the care plans to know what the plan of care was. The Registered Nurse, Employee #2, did confirm the dietician had not been informed of Patient #22's specific nutritional needs. She confirmed that the food preferences identified by the dietary department had not been incorporated into the care plan. The Registered Nurse, Employee #2, also confirmed the care plan and the nursing documentation did not reflect whether the 2000 cc/ per shift fluid recommendation was realistic or whether the CNA was following the plan of care to encourage fluids. Patient #2 was admitted on 3/1/09 with the primary diagnosis of hypocoagulation state. The history and physical indicated Patient #2 may have been taking her Coumadin inappropriately, resulting in an overdosage and an increase risk of bleeding The clinical record revealed a care plan identifying Patient #2 with an increased risk of injury. The clinical record revealed that Patient #2 was found on the floor at 10:30 PM on 3/2/09. Bruising developed around Patient #2's left eye, left hip and right shoulder. The care plan was not revised to indicate the fall and resulting injuries. There was also no care plan to identify needs of better medication management and family teaching for when Patient #2 returned home. Patient #3 was admitted to the facility on 2/24/09.	C 298		

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C 298	Continued From page 15 The physician's history and physical indicated Patient #3 had elevated lab values related to Patient #3's use of Aleve. Patient #3 was also anemic. Review of the care plans or nursing note documentation revealed no evidence that Patient #3 was given any teaching on the proper use of Aleve or other pain medications. Patient #3 was discharged 3/3/09. Patient #1 was admitted to the facility on 2/27/09 and discharged 3/3/09. His admitting diagnoses included fecal impaction and small bowel obstruction. An interview with the Charge Nurse on 3/3/09, revealed that Patient #1 had a history of laxative abuse which caused his fecal impaction. She confirmed that the care plan for constipation did not include any interventions to instruct a patient on proper diet of roughage and fluid intake, avoiding foods that constipate or education on healthy bowel habits. She confirmed Patient #1 had been discharged. She confirmed there was no discharge care plan to instruct the family regarding Patient #1's bowel management. An interview with the Director of Nursing on 3/4/09 confirmed the care plans were to be individualized and updated as needed but that the staff did not always comply.	C 298		
C 304	485.638(a)(4)(i) RECORDS SYSTEMS For each patient receiving health care services, the CAH maintains a record that includes, as applicable- (i) identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the	C 304		

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C 304	Continued From page 16 patient, and a brief summary of the episode, disposition, and instructions to the patient; This STANDARD is not met as evidenced by: Based on record review, policy review, and interview the facility failed to obtain properly executed informed consent for 5 of 5 surgical patients (#9, #10, #11, #12, #14). Findings include: Patient #10 was admitted on 7/24/08 for an outpatient surgery. Review of Patient #10's medical record revealed the procedure listed on the consent was, "Fuse 3rd Toe PPJ and fuse 4th toe PPJ". Interview with the Director of Nurses (DON) revealed that PPJ was proximal phalangeal joint and should have been written out. Patient #11 was admitted on 10/23/08 for an outpatient surgery. Review of Patient #11's medical record revealed the procedure listed on the consent was, "left wrist CTS release." Interview with the DON revealed CTS was carpal tunnel syndrome and should have been written out. Patient #12 was admitted on 1/2/09 for an outpatient surgery. Review of Patient #12's medical record revealed the procedure on the consent was listed as, "cataract removal/phaco IOL OS." Interview with the DON revealed the procedure was cataract removal/phaco emulsification with intraocular lens left eye. The DON confirmed that abbreviations should not be used on a consent.	C 304		

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C 304	Continued From page 17 Patient #9 was admitted on 7/23/08 for an outpatient surgery. Review of Patient #9's medical record revealed a consent for colonoscopy. Record review revealed the patient had a colonoscopy with removal of three polyps. Patient #14 was admitted on 1/21/09 for an outpatient surgery. Review of Patient #14's medical record revealed a consent for a colonoscopy. Record review revealed the patient had an esophagogastroduodenoscopy, colonoscopy, and a banding of hemorrhoids. On 3/4/09, the DON was interviewed. She confirmed that the consents for Patient #9 and #14 should have listed all procedures that were done. The facility's policy and procedure for obtaining informed consent was reviewed. The nature of the treatment must be listed on the consent. Any medical information set forth "needs to be written in clear, simple, and easily understood terms."	C 304		
C 305	485.638(a)(4)(ii) RECORDS SYSTEMS [For each patient receiving health care services, the CAH maintains a record that includes, as applicable-] (ii) reports of physical examinations, diagnostic and laboratory test results, including clinical laboratory services, and consultative findings; This STANDARD is not met as evidenced by: Based on record review and interview the facility failed on maintain a surgical record that included diagnostic laboratory results for 1 of 5 surgical patients (#9).	C 305		

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C 305	Continued From page 18 Findings include: Patient #9 was admitted on 7/23/08 for a colonoscopy. Record review revealed the patient had three polyps removed and one was sent for histology. Further record review failed to reveal the results of the pathology examination. On 3/4/09, a medical record's employee was interviewed. She stated that the pathology reports went to the physician and that the facility did not always receive one. On 3/4/09, the director of laboratory services was interviewed. She confirmed there was a specimen sent to the lab for Patient #9 on 7/23/08.	C 305		